

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155614		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/30/2012	
NAME OF PROVIDER OR SUPPLIER  LINCOLN HILLS OF NEW ALBANY				STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150			
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: October 23, 24, 25, 26, 29, and 30, 2012</p> <p>Facility number: 000321 Provider number: 155614 AIM number: 100286130</p> <p>Survey team: Gloria J. Reisert, MSW/TC Jill Ross, RN Diana Sidell, RN Cheryl Fielden, RN (10/23, 24, 25 ,29 and 30, 2012)</p> <p>Census bed type: SNF: 7 SNF/NF: 120 Total: 127</p> <p>Census payor type: Medicare: 6 Medicaid: 98 Other: 23 Total: 127</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on</p>			F0000	<p>Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, the response and plan of correction constitutes Lincoln Hills of New Albany's allegation of compliance in accordance with Section 7305 in the State Operations Manual.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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	November 7, 2012 by Bev Faulkner, RN						

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on record review and interview, the facility failed to do a</p>		F0441	The facility will continue to establish and maintain an		11/29/2012	

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	<p>2nd PPD (tuberculosis skin test) after a resident was admitted to the facility. This affected 1 of 5 residents reviewed for PPDs. (Resident #136)</p> <p>B. Based on record review, observation and interview, the facility failed to ensure their infection control policies related to hand hygiene during meal service were followed during 1 of 1 dining room and 1 of 3 room tray meal observations.</p> <p>Findings include:</p> <p>A. 1. Record review for Resident #136 was done on 10/24/12 at 8:52 a.m. Her diagnoses included but were not limited to: Seizures, cataract, and emphysema. Her admission date was 1/28/12. She entered the facility at 5:30 p.m., and the 1st step PPD was done at 6:00 a.m., on 1/29/12. There was no documentation found in the clinical record to show there was a 2nd PPD done.</p> <p>During interview with the Medical Records Director on 10/30/12 at 9:07 a.m., she indicated she found no documentation of the 2nd step PPD having been done in the active record or in her overflow records.</p>				<p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. For Resident #136, the physician was notified that a second step ppd was not completed upon admission. MD reviewed this resident's current clinical condition with no new orders noted. All new admissions have the potential to be affected. The medical record for all residents were audited for timely completion of ppds. Licensed staff have been inserviced regarding the facility's policy for administration of two step ppd upon admission. Nursing managers will review the medical record of each new admission to ensure that first and second step ppds are administered in a timely manner. Results of these audits will be reported to the Director of Nursing. DON will ensure that additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee for a minimum of four quarters. DON and Administrator to monitor. RN #3 and the MDS Coordinator have been inserviced regarding facility's policy for tray pass and handwashing. All residents have the potential to be affected. All staff responsible for meal service have been</p>		

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	<p>Review of the policy titled, "Tuberculosis Exposure Control Plan" received on 10/30/12 at 9:45 a.m., from the Administrator, included:</p> <p>"...Resident Screening Standards:...1...b. Results of a two-step diagnostic intermediate strength PPD, if not a reactor, shall have been completed within three months of admission, or administered at the time of admission...2...a. Each resident shall have evidence of a two-step Mantoux test (PPD) to establish baseline data. The second test shall be administered at least one week and no more than three weeks after the first test if the measurement is 0-9 mm..."</p> <p>B.1. During a room tray pass observation on C Hall on 10/23/2012 between 11:40 a.m. and noon, the following was observed:</p> <p>- 11:40 a.m. - RN #3 set up the tray for Room 6 and placed it on the overbed table that was off to the side. She then moved the resident's wheelchair into position touching the wheel of the chair and then moved the overbed table in front of the resident grasping the table from the sides. The nurse then helped cut-up the resident's food using his</p>				<p>inserviced regarding facility's policy for tray pass and handwashing. Nursing managers will conduct observations of room tray pass and dining room meal service to ensure facility policy is followed. These audits will be completed weekly times four weeks; every other week times four weeks and then monthly. Results of these observations will be reported to the DON. DON will ensure that additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of four quarters. DON and Administrator to monitor.</p>		

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	<p>silverware and then gave the silverware to the resident to use. Upon leaving the room, no handwashing or alcohol gel was observed to sanitize the RN's hands before moving onto the next room.</p> <p>- 11:43 a.m. - RN #3 then picked up the tray for Room 3, placed it on the overbed table for the resident and then left the room.</p> <p>- 11:44 a.m. - RN #3 then picked up the tray for Room 7, placed it on the overbed table, moved the resident's open box of tissues off to the side, rubbed hands along the side of the overbed table as she pushed it in front of the resident. The RN then picked up the resident's silverware to cut up the resident's chicken and again moved the table closer to the resident. She then left the room. No handwashing or alcohol gel was observed to have been used after leaving the resident's room.</p> <p>During an interview with RN #3 at 11:48 a.m., she indicated she was not aware of this facility's policy on whether or not one needed to sanitize hands between tray pass. She indicated that she probably should have used alcohol gel in between each tray pass, but did not think she</p>						

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	<p>touched anything but the residents' trays. She then indicated that after thinking about it for a moment, she realized she had touched the resident's wheelchair and several overbed tables when setting up food trays.</p> <p>During an interview with the Director of Nursing [DoN] on 10/30/12 at 9:30 a.m., she indicated that staff should wash their hands at the beginning of tray pass, but that unless the staff touched the resident or the table/wheelchair was visibly soiled, there was no need to wash or alcohol gel hands in between. She did indicate that if the nurse touched the resident's wheelchair wheels, then she should have washed her hands.</p> <p>2. Observation of lunch in the main dining room on 10/23/12 at 11:42 a.m., the MDS (Minimum Data Set) Coordinator was observed buttering a resident's muffin with unwashed and ungloved hands.</p> <p>The current policy and procedure provided by the DON (Director of Nursing) on 10/30/12 at 8:22 a.m., titled "Hand Washing Policy" included but was not limited to the following,... "Hand washing will be practiced as follows: i. Before</p>						

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	handling food or food trays and after feeding a resident."  3.1-18(l) 3.1-18(j)						

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F0465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a safe, comfortable and sanitary environment during 1 of 1 observations, in that water damaged ceiling tiles with mold were observed in the hot water heater room and the East Hall supply room.</p> <p>Finding includes:</p> <p>During the environmental tour on 10/29/12 at 2:00 p.m., water damaged ceiling tiles with mold were observed in two locations in the facility. Water damaged ceiling tiles with mold were observed in the upper right hand corner of the hot water heater room, and in the back upper right corner of the East Hall supply room.</p> <p>During an interview on 10/29/12 at 2:00 p.m., the Maintenance Director indicated the ceiling tiles were water damaged and it appeared to be mold on the tile.</p> <p>3.1-19(f)</p>			F0465	<p>The facility will continue to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The ceiling tiles in the hot water heater room and the East Hall Supply Room were replaced. All ceiling tiles have been inspected and replaced as necessary. During weekly environmental rounds, ceiling tiles will be inspected for water damage and replaced as necessary. Results of these rounds will be reported to the Administrator. Administrator will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of four quarters. Administrator to monitor.</p>		11/29/2012

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F0516 SS=B	<p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation and interview, the facility failed to ensure that 20 boxes of closed records were stored in a manner that protected them from loss and destruction. .</p> <p>Findings include:</p> <p>On 10/29/12 at 2:00 p.m., during the environmental tour with the Maintenance Director, the medical records storage room was observed. Twenty (2) cardboard boxes, that contained closed medical records, were stored underneath the sprinkler heads and not protected from water destruction.</p> <p>During an interview on 10/29/12 at 2:00 p.m., the Maintenance Director indicated the records were not stored in a manner to protect them from</p>			F0516	<p>The facility will continue to safeguard clinical record information against loss, destruction or unauthorized use. The facility has installed a waterproof covering over the closed records in the medical records storage room. During weekly rounds, the Maintenance Supervisor will monitor compliance. Results will be reported to the Administrator. Administrator will ensure that additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly until such time that the committee deems a reduction is warranted. Administrator to monitor.</p>		11/29/2012

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	water damage.  3.1-50(d)						